STATE OF ARIZONA
DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 01A-214-INS
CIGNA HEALTHCARE OF ARIZONA, INC. (NAIC No. 95125)	CONSENT ORDER
Respondent.	

A health care appeals audit was made of CIGNA HealthCare of Arizona, Inc., hereinafter referred to as "CIGNA," by the Health Care Appeals Examiner for the Arizona Department of Insurance (the "Department") and was completed on April 18, 2001. The audit covered expedited medical review appeals, informal reconsideration appeals, formal appeals, and external independent review appeals from January 1, 2000 through December 31, 2000. Based upon the audit results, it is alleged that CIGNA has violated the provisions of A.R.S. §§20-461, 20-2534, 20-2535, and 20-2536.

The Examiner reviewed CIGNA's health care appeals procedures, expedited, informal, formal, and external health care appeals files, and other materials sent to the Department in response to the audit call letter.

CIGNA wishes to resolve these matters without formal adjudicative proceedings, admits the following Findings of Fact are true and consents to entry of the following Conclusions of Law and Order.

FINDINGS OF FACT

1. CIGNA is an Arizona domiciled health care services organization authorized to transact health insurance business pursuant to a certificate of authority issued by the Director.

2. The Examiner was authorized by the Director to conduct a heath care appeals audit of CIGNA and has prepared a Report of Examination of the Health Care Appeals of CIGNA ("the Report").

3. The Examiner reviewed 3 expedited medical review appeals and found that each of the files contained a deficiency. The deficiencies are as follows:

a. CIGNA notified the member in one case of a timeframe within which it would render an expedited medical review decision that was inconsistent with the timeframe provided by law.

b. CIGNA failed to render one expedited medical review decision within one business day of receiving the request.

c. CIGNA notified one member in a denial letter that the member's appeal must be made in writing.

4. The Examiner reviewed 50 informal reconsideration appeals, and found that 42 files contained at least one deficiency. The deficiencies are as follows:

a. CIGNA failed to distribute information packets to the member in four cases in which the member's informal reconsideration appeal was denied. In an additional five cases, CIGNA did not distribute information packets to the member where the member's informal reconsideration appeal was approved within the timeframe allowed by law. CIGNA also failed to distribute information packets to the treating provider in ten cases in which the member's informal reconsideration appeal was denied. In an additional five cases, CIGNA did not distribute information packets to the treating provider where the member's informal reconsideration appeal approved within the timeframe allowed by law.

b. CIGNA failed to send a separate written acknowledgement of the request for appeal to the treating provider in eight cases in which the member's informal reconsideration appeal was denied. In an additional six cases, CIGNA did not send a separate written acknowledgement of the request for appeal to the treating provider where the member's informal reconsideration appeal was approved within the timeframe allowed by law, and the member and treating provider were both notified of the approval in writing.

c. CIGNA failed to send written notice of the decision to the treating provider in fifteen cases.

d. CIGNA failed to inform the member in four cases of the right to request a formal appeal following the informal reconsideration, and if the formal appeal is upheld, of the right to request an external independent review.

e. CIGNA failed to include the criteria used and the clinical reasons for the decision in twenty-eight cases, of which four were denied and twenty-four were approved within the timeframe allowed by law.

f. CIGNA notified members in ten cases that appeals of informal reconsideration decisions must be requested in writing.

5. The Examiner reviewed 75 formal appeals, and found that 8 files contained at least one deficiency. The deficiencies are as follows:

a. CIGNA failed to send an acknowledgment letter of the formal appeal request and distribute a health care appeals information packet to the treating provider in two cases.

b. CIGNA failed to send written acknowledgment within five business days of receiving the appeal request in one case.

c. CIGNA notified the provider in one case of a timeframe within which to appeal that was inconsistent with the timeframe permitted by law.

d. CIGNA failed to have appeal decisions rendered by a physician or other appropriate health care professional by refusing to follow the recommendations of the physicians in two cases.

CONCLUSIONS OF LAW

1. CIGNA violated A.R.S. §20-2534(B) and by failing to render an expedited medical review decision within one business day of receiving the request for review.

2. CIGNA violated A.R.S. §20-2535(B) (1999) and §20-461(A)(17) by failing to send members and their treating providers acknowledgment letters and health care appeals information packets within five business days of receiving the appeal requests.

3. CIGNA violated A.R.S. §20-2535(D) and §20-461(A)(17) by failing to send written notice of the decision to treating providers following informal reconsideration appeals.

4. CIGNA violated A.R.S. §20-2535(F) and §20-461(A)(17) by failing to inform members of the right to request formal appeal following informal reconsideration, and if the formal appeal is upheld, of the right to an external independent review.

5. CIGNA violated A.R.S. §§20-2535(D) and (F) by failing to include the criteria and clinical reasons for its appeal denials in informal reconsideration decision letters.

6. CIGNA violated A.R.S. §20-2536(B) (1999) by failing to send acknowledgment letters of formal appeal requests and health care appeals information packets to members and their treating providers within five business days of receiving the appeal requests.

7. CIGNA violated A.R.S. §20-2536(D) (1999) by failing to have a physician or other appropriate health care professional as defined by law render formal appeal decisions.

ORDER

IT IS HEREBY ORDERED THAT:

1. Within 90 days of the filed date of this Order, Respondent shall develop an action plan outlining procedures that will ensure the following:

a. All denial letters will advise the member or treating provider of the correct information regarding the ability to appeal denials and the proper timeframes applicable to those appeals, consistent with A.R.S. §§20-2533(D), 20-2534(B), 20-2535(A) and 20-2536(A).

b. All expedited medical review decisions are rendered within 1 business day of receiving the request and physician certification pursuant to A.R.S. §20-2534(B).

c. All expedited medical review acknowledgment letters will advise the member or provider of the appropriate timeframe within which a decision will be rendered, consistent with A.R.S. §20-2534(B).

d. All treating providers are sent written acknowledgment letters of requests for informal reconsiderations and formal appeals pursuant to A.R.S. §§20-2535(B) and 20-2536(B).

The acknowledgement may be stated in an approval letter to the member and treating provider, if the member's request for informal reconsideration is approved.

e. All treating providers are sent a written notice of the decision following the completion of all informal reconsideration appeals pursuant to A.R.S. §20-2535(D).

f. All informal reconsideration decision letters that uphold the original denial will advise the member of the right to request a formal appeal, and if the formal appeal is upheld, of the right to request an external independent review, pursuant to A.R.S. §20-2535(F).

g. All decision letters following the completion of informal reconsideration appeals will include the criteria used and clinical reasons for the decision, consistent with A.R.S. §20-2535(D) and (F).

h. Written acknowledgment letters of formal appeals will be sent to members and their treating providers within 5 business days of receiving the appeal request pursuant to A.R.S. §20-2536(B).

i. All denials based on medical necessity that are overturned by the reviewing specialist during a formal appeal will result in the denial being reversed at the completion of the formal appeal, consistent with A.R.S. §20-2536(D).

2. Within 90 days of the filed date of this Order, Respondent shall provide the Department with a copy of the action plan developed pursuant to Paragraph One of this section of the Order.

3. Within 30 days of the filed date of this Order, Respondent shall provide benefits for members whose claims were denied in cases #52627122304 and #274582301.

4. CIGNA shall perform a self-audit of all formal appeals to identify any cases wherein the physician specialist reviewer recommended that the denied claim or service be authorized, but CIGNA nevertheless denied the claim or service at the conclusion of the formal appeal. CIGNA shall provide the results of this self-audit to the Department within 30 days of the filed date of this Order.

5. CIGNA shall pay a civil penalty of $5,000.00 to the Director for remission to the State Treasurer for deposit in the State General Fund in accordance with A.R.S. §20-220(B). Said

amount shall be provided to the Health Care Appeals Section of the Department prior to the filing of this Order.

6. The Report of Examination dated April 18, 2001, and any objections to the Report submitted by CIGNA, shall be filed with the Department upon the filing of this Order.

DATED this 10th day of September, 2001.

Charles R. Cohen
Director of Insurance

CONSENT TO ORDER

1. Respondent, CIGNA HealthCare of Arizona, Inc., has reviewed the foregoing Order.

2. Respondent admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Finding of Facts are true, and consents to the entry of the Conclusions of Law and Order.

3. Respondent is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. Respondent irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

4. Respondent states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. Respondent acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter and does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future.

6. Jeffrey S. Terrill, who holds the office of Senior Vice President General Manager of Respondent, is authorized to enter into this Order for it and on its behalf.

CIGNA HealthCare of Arizona, Inc.

8/27/01 (date) By _____

COPY of the foregoing mailed/delivered this 12th day of September, 2001 to:

Sara Begley
Deputy Director

Vista Brown
Executive Assistant
Gerrie Marks
Executive Assistant
Catherine O'Neil
Consumer Legal Affairs Officer/Custodian of Records
Mary Butterfield
Assistant Director
Consumer Affairs Division
Alexandra Shafer
Assistant Director
Life and Health Division
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